SECTION 10

Post-acute care

Skilled nursing facilities
Home health services

Chart 10-1. The number of post-acute care providers generally continues to grow

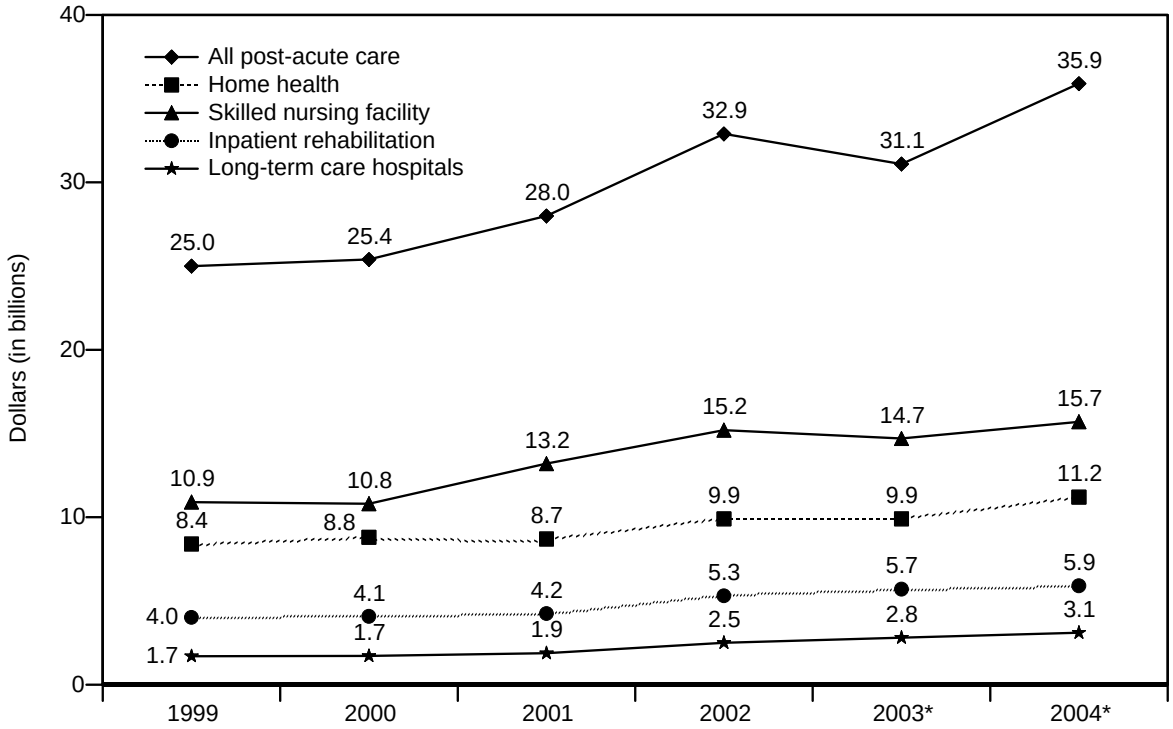
	1994	1996	1998	2000	2002	2004	2005	Percent change 1994–2005
Skilled nursing facilities*	13,945	14,548	16,079	16,275	15,089	15,784	15,632	12%
Home health agencies	8,003	9,808	9,284	7,317	6,888	7,148	7,874	–2
Inpatient rehabilitation	1,001	1,031	1,078	1,102	1,181	1,206	1,232	23
Long-term care hospitals	146	183	209	240	286	307	365	147

Note: * Includes swing bed hospitals.

Source: Online Survey, Certification, and Reporting system from CMS.

- The number of post-acute care providers increased in most settings from 1994 to 2005.
- The number of skilled nursing facilities increased by 12 percent from 1994 to 2005, although it has declined since 2000.
- The number of home health agencies increased by 50 percent from 1994 to their peak in 1996 and then dropped back to 1994 levels. This may be due to many factors, including: the interim payment system, increased program integrity scrutiny, surety bond requirements, and other factors. The number has begun to increase again in the most recent periods.
- Inpatient rehabilitation facilities increased by 23 percent from 1994 to 2005.
- The number of long-term care hospitals more than doubled from 1994 to 2005.
- More information can be found in Chapter 5 of MedPAC's June 2005 Report to the Congress, and Chapters 2C and 2D of MedPAC's March 2005 Report to the Congress. These reports are available at http://www.medpac.gov/publications/congressional_reports/June05_Ch5.pdf, http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02c.pdf, and http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02d.pdf, respectively.

Chart 10-2. Spending for post-acute care, by setting, 1999–2004



Note: These numbers are program spending only, and do not include beneficiary copays.
*Estimated.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

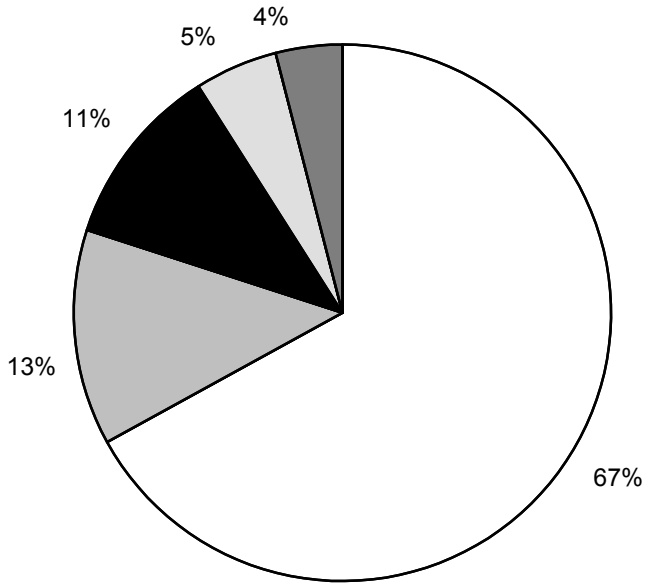
- Medicare has prospective payment systems (PPSs) for the four post-acute care settings. CMS implemented these PPSs at the following times: skilled nursing facilities, July 1998; home health agencies, October 2000; inpatient rehabilitation facilities, January 2002; and long-term care hospitals, October 2002. Although CMS intended to use these payment systems to control Medicare spending for post-acute care, spending has increased an average of 7 percent per year since 1999.

- From 1999 through 2004, Medicare spending for long-term care hospitals has increased the most—at 13 percent per year. During the same period, spending for skilled nursing facilities and inpatient rehabilitation facilities each increased 8 percent per year, and home health agencies increased 6 percent per year. For 2004, CMS estimated that total spending for post-acute care was almost $36 billion.

- Post-acute care currently makes up about 12 percent of Medicare's total spending.

- More information can be found in Chapter 5 of MedPAC's June 2005 Report to the Congress, and Chapters 2C and 2D of MedPAC's March 2005 Report to the Congress. These reports are available at http://www.medpac.gov/publications/congressional_reports/June05_Ch5.pdf, http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02c.pdf, and http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02d.pdf, respectively.

Chart 10-3. One-third of beneficiaries discharged from hospitals use post-acute care, 2002

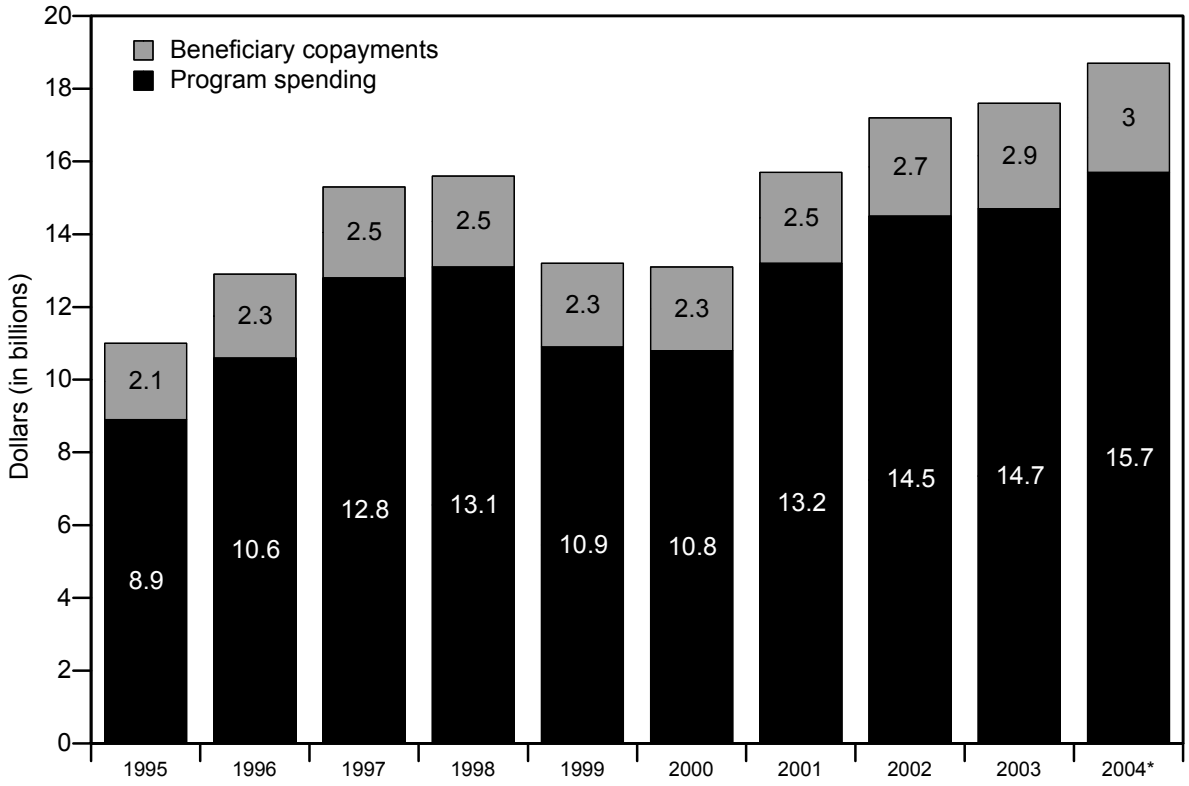


Note: LTCH (long-term care hospital), IRF (inpatient rehabilitation facility), IPF (inpatient psychiatric facility), PAC (post-acute care).

Source: *Medicare beneficiaries' use of post-acute care trends, 1996 to 2002*. Report submitted to MedPAC by Christopher Hogan, Direct Research, September 2, 2004.

- The most common single post-acute care destination for beneficiaries discharged from acute hospitals is a skilled nursing facility. The second most common is home health care.
- Though some episodes involve multiple settings, the most common episode includes only one post-acute setting.
- Two-thirds of beneficiaries discharged from the hospital use no post-acute care.

Chart 10-4. Medicare spending for skilled nursing facility services generally increased over the decade 1995–2004



Note: Spending is for Part A services.
* Estimated.

Source: CMS, Office of the Actuary, 2004.

- Total Medicare spending on skilled nursing facility (SNF) services grew rapidly (averaging 19 percent per year) from fiscal year 1993 through fiscal year 1998.

- In fiscal year 1999, immediately following the implementation of the SNF prospective payment system, total Medicare spending on SNF services fell from $15.6 billion to $13.2 billion. Prior to fiscal year 1998, Medicare paid SNFs based on their costs, subject to some limits.

- A number of factors contributed to the increase in total Medicare spending for SNF services from fiscal year 2000 to fiscal year 2004, including increases in the use of SNF services and increases in payment rates over the period. Payment rate increases occurred both because of annual updates and because of temporary payment add-ons mandated in the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement & Protection Act of 2000.

Chart 10-5. Medicare skilled nursing facility use increased between 1999 and 2002

Year	Number of admissions (thousands)	Number of days (millions)	Days per admission
1999	1,796	42.4	23.6
2000	1,824	43.8	24.0
2001	1,950	47.9	24.6
2002	2,223	54.7	24.6
Increase 2001-2002	14.0%	14.1%	.11%
Average annual increase	7.4%	8.8%	1.4%

Note: Data include facilities in Puerto Rico, Virgin Islands, and "unknown." Data do not include swing bed units.

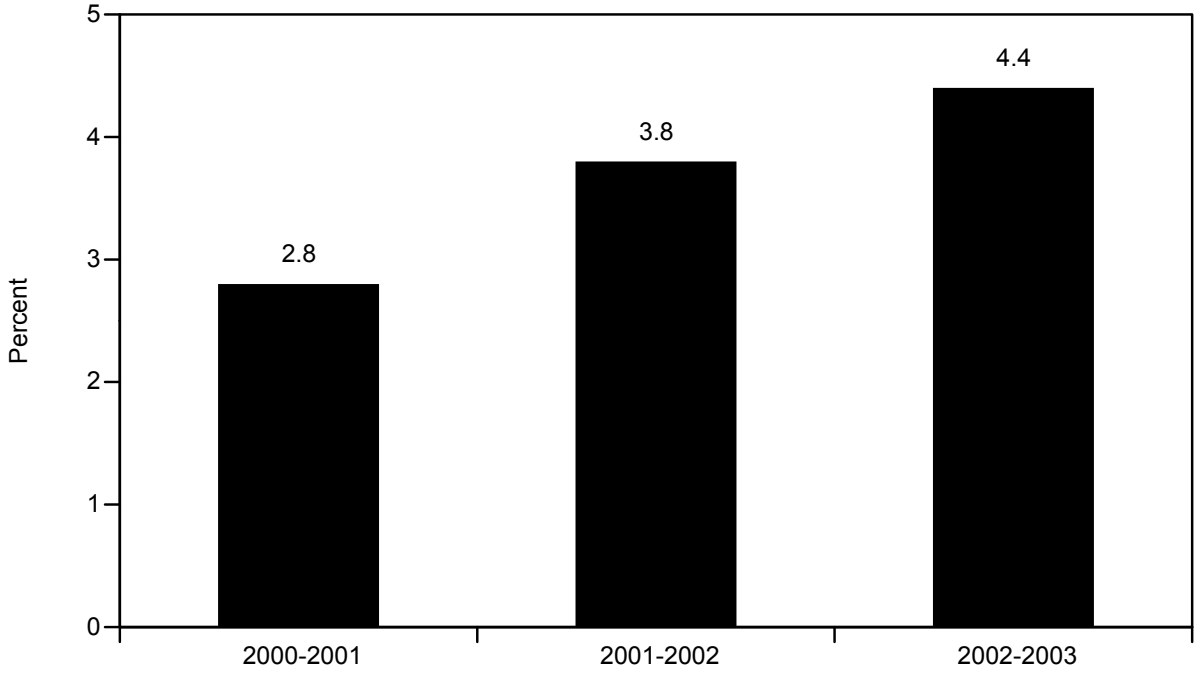
Source: SNF MedPAR stay records from CMS, Office of Research, Development, and Information.

- The number of Medicare admissions to skilled nursing facilities (SNF) grew at an average annual rate of 7.4 percent between 1999 and 2002. Increased SNF use exceeds the rate of growth in the Medicare population; during this same period the average annual increase in the number of Part A enrollees was just 1.1 percent.

- Growth in the number of admissions between 2001 and 2002 was almost twice the average annual rate of growth between 1999 and 2002. The number of SNF admissions increased 14 percent between 2001 and 2002, the most recent years for which we have data. Similarly, the number of SNF days increased 14.1 percent between 2001 and 2002.

- The average length of stay for Medicare patients in a SNF increased by one day between 1999 and 2002.

Chart 10-6. Medicare costs per day in freestanding SNFs grew at an average annual rate of 3.6 percent between 2000 and 2003

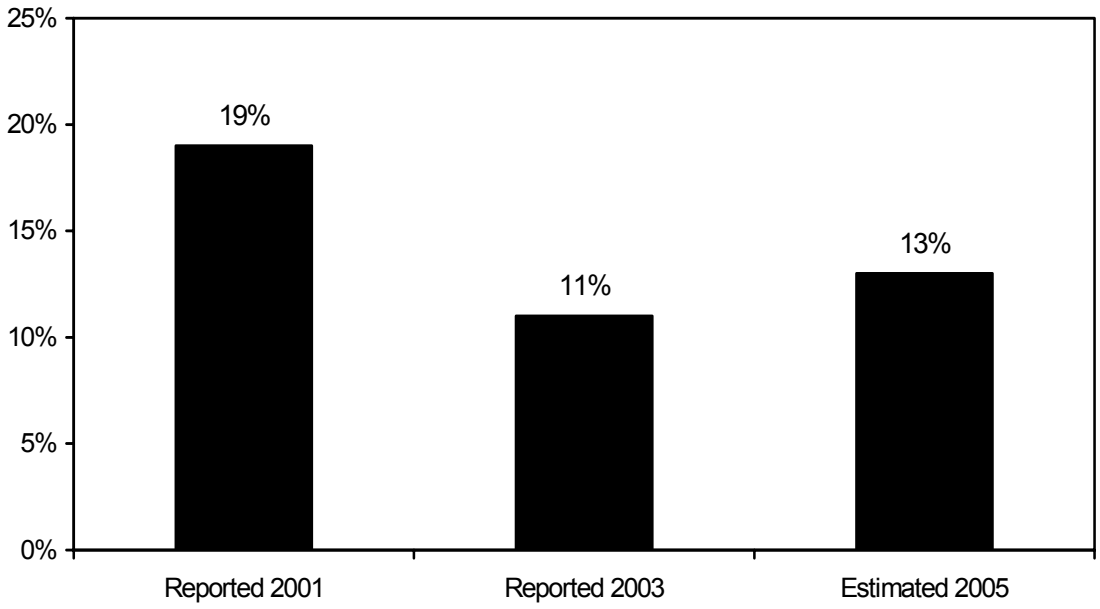


Note: SNF (skilled nursing facility). Medicare cost growth per day was calculated from year to year among the cohort of freestanding SNFs that submitted cost reports in all four years.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Per-day costs in freestanding SNFs for Medicare beneficiaries grew 3.6 percent annually between 2000 and 2003, with the most recent period seeing a higher rate of growth.
- At the 25th percentile of the distribution, per-day costs in freestanding SNFs for Medicare beneficiaries grew 0.4 percent annually between 2000 and 2003; at the 75th percentile, these costs grew 7.9 percent.

Chart 10-7. Medicare margins for freestanding skilled nursing facilities continue to be in the double digits, 2001, 2003, and estimated 2005



Note: Margin is calculated as revenue minus costs, divided by revenue.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Additional information on Medicare margins for skilled nursing facilities can be found in Chapter 2C of MedPAC's March 2005 Report to the Congress available at http://www.medpac.gov/publications/congressional_reports/mar05_CH02C.pdf.

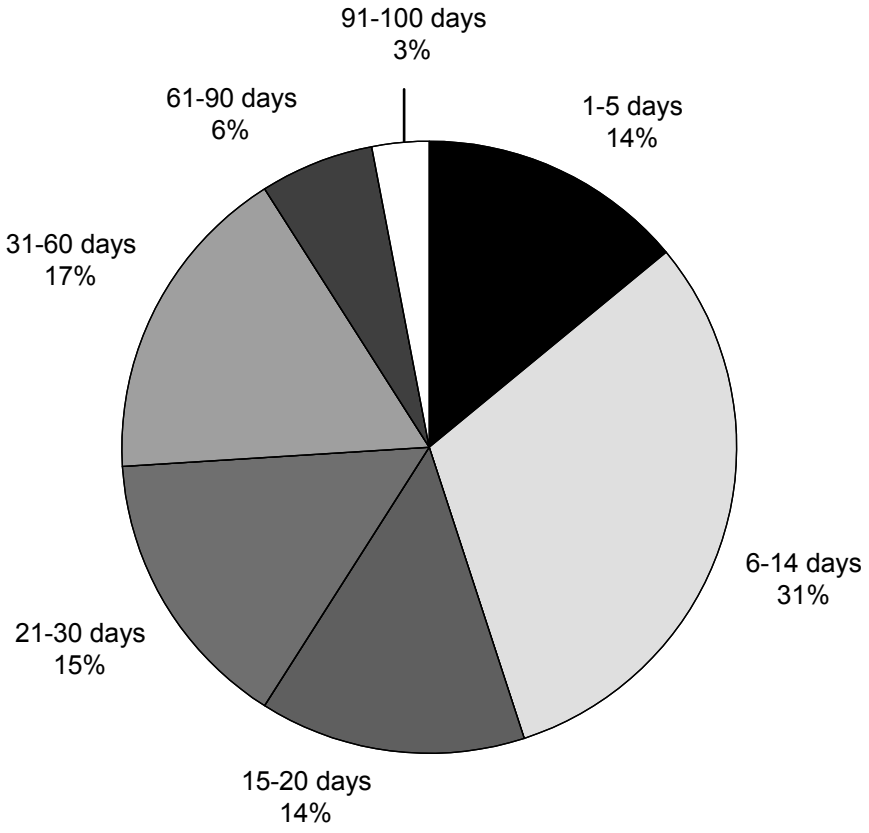
- The Medicare margin in fiscal year 2005 is about 13 percent. This represents the combination of three changes in the payment rates since fiscal year 2001:

  -The expiration of two temporary payment add-ons at the end of fiscal year 2002.

  -An administration action which resulted in a 3.26 percent increase in SNFs' fiscal year 2004 base rates to correct for errors in forecasting the SNF market basket index for fiscal years 2000 through 2003. This correction was in addition to the full market basket update of 3.0 percent in fiscal year 2004.

  -A full 3 percent update in these rates for fiscal year 2005.

Chart 10-8. Distribution of SNF stays, by length of stay, in 2001



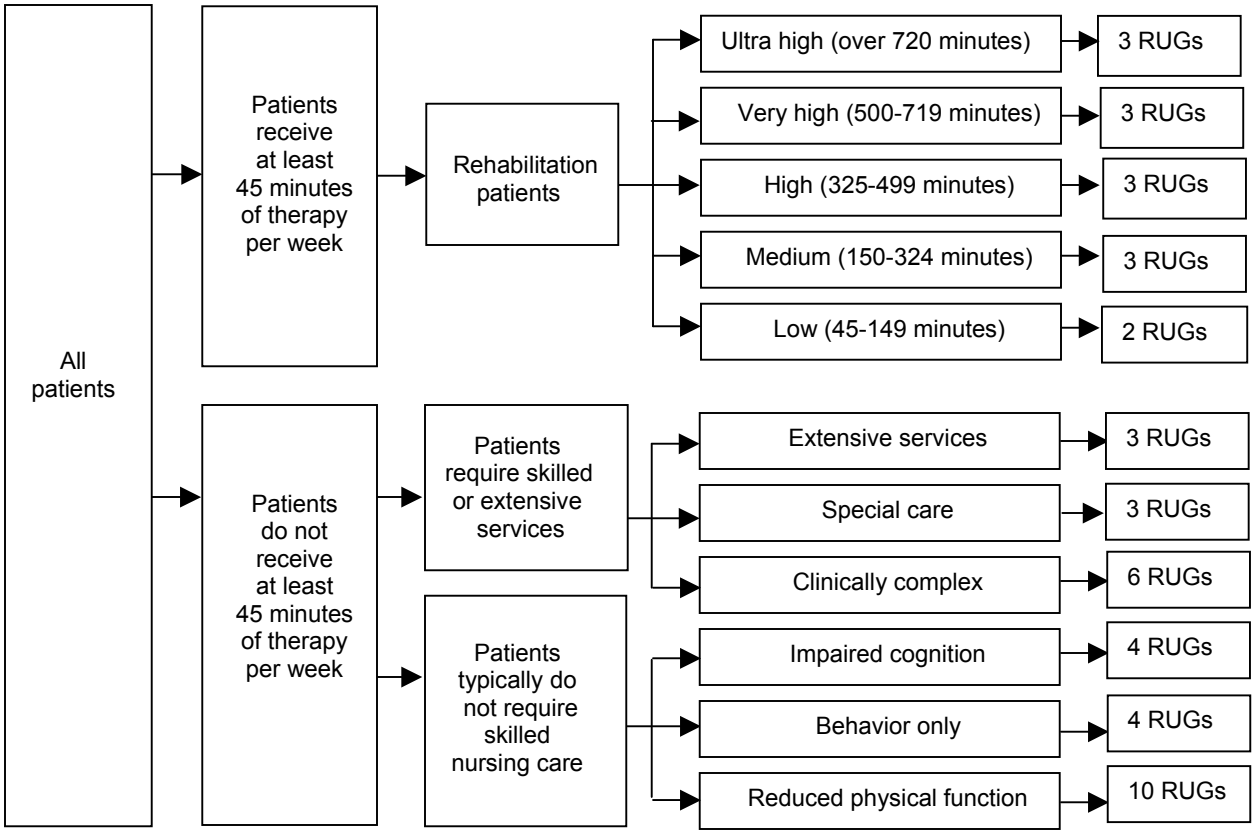
Note: SNF (skilled nursing facility).

Source: MedPAC analysis of SNF stay file for SNF admissions in 2001.

- The SNF payment system pays hospital-based and freestanding SNFs a case-mix adjusted daily rate for up to 100 days of care per beneficiary. However, about 60 percent of SNF stays lasted just 20 or fewer days in 2001, and only about 9 percent of covered SNF stays were longer than 60 days.

- The mean length of stay (LOS) for all Medicare-covered SNF stays was about 24 days—with hospital-based SNFs having shorter mean LOS (14 days) than freestanding SNFs (28 days).

Chart 10-9. RUG–III classification scheme



Note: RUG-III (resource utilization group, version III).

Source: Figure adapted from GAO 2002.

- Medicare's payment system adjusts SNF nursing and therapy base rates for expected resource use, employing weights associated with each of the 44 RUG–III categories. The 44 groups fall into seven major categories: (1) rehabilitation, (2) extensive services, (3) special care, (4) clinically complex, (5) impaired cognition, (6) behavior only, and (7) reduced physical function.

- Beneficiaries are assigned to a RUG–III category based on the number of minutes of therapy (physical, occupational, or speech) that the patient has used or is expected to use; the need for certain services (e.g., respiratory therapy); the presence of certain conditions (e.g., pneumonia); an index based on the patient's ability to independently perform four activities of daily living (ADLs) (eating, toileting, bed mobility, and transferring); and—in some cases—signs of depression.

- The RUG–III system is hierarchical; beneficiaries may qualify for multiple categories, but the classification system assigns them to the highest payment category for which they qualify.

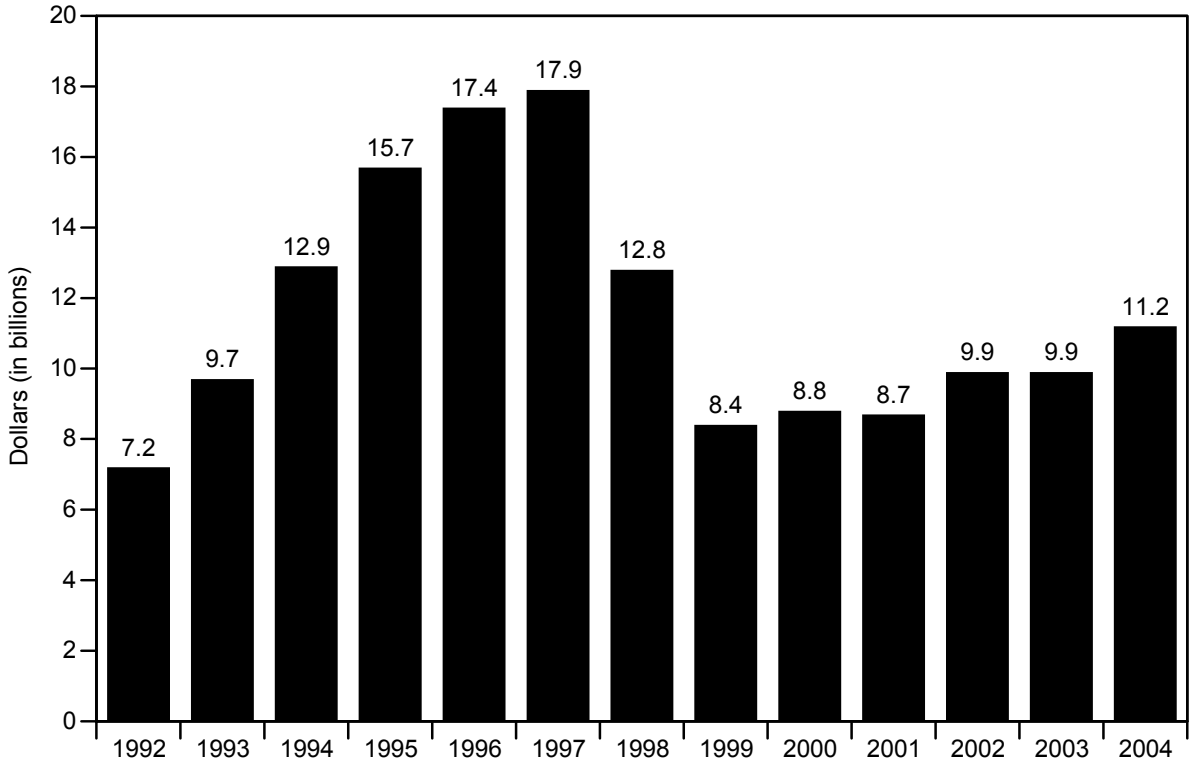
Chart 10-10. The highest percentage of Medicare-covered freestanding SNF days were in "very high" and "high" rehabilitation RUG–III groups in 2003

RUG–III group	Percent of Medicare days
Rehabilitation	**77.8%**
Ultra high, 16–18 ADL	1.7
Ultra high, 9–15 ADL	5.7
Ultra high, 4–8 ADL	1.6
Very high, 16–18 ADL	3.2
Very high, 9–15 ADL	15.2
Very high, 4–8 ADL	5.2
High, 13–18 ADL	14.8
High, 8–12 ADL	12.0
High, 4–7 ADL	4.3
Medium, 15–18 ADL	4.7
Medium, 8–14 ADL	7.0
Medium, 4–7 ADL	2.3
Low, 14–18 ADL	0.2
Low, 4–13 ADL	0.2
Extensive services	**7.0**
7–18 ADL, 4–5 services	3.0
7–18 ADL, 2–3 services	3.8
7–18 ADL, 0–1 services	0.2
Special care	**6.1**
17–18 ADL	1.4
15–16 ADL	2.0
7–14 ADL	2.7
Clinically complex	**6.3**
17–18 ADL, depression	0.2
17–18 ADL, no depression	0.6
12–16 ADL, depression	0.6
12–16, no depression	2.1
4–11, depression	0.7
4–11, no depression	2.2
Nonskilled RUGs	**2.3**
Unknown RUG	0.3

Note: SNF (skilled nursing facility), RUG–III (resource utilization group, version III), ADL (activity of daily living).

Source: MedPAC analysis of Medicare cost report data from CMS, 2003. Total percent may not add to 100 due to rounding. ADLs are expressed in terms of an index. The higher the index, the greater the patient's limitation on activities of daily living. "Services" is a count of the services or conditions that qualify a beneficiary for the extensive services category. The higher the number of services, the greater the anticipated resource use within the extensive services category.

Chart 10-11. Spending for home health care, 1992–2004



Source: CMS, Office of the Actuary, 2004.

- Medicare home health care spending grew at an average annual rate of 20 percent from 1992 to 1997. During that period, the payment system was cost based. Eligibility had been loosened just before this period and enforcing the program's standards became more difficult.
- Spending began to fall in 1997, concurrent with the introduction of the interim payment system (IPS) based upon costs with limits, tighter eligibility, and increased scrutiny from the Office of Inspector General.
- In 2000, the prospective payment system replaced the IPS. At the same time, eligibility for the benefit was broadened slightly. The regional home health intermediaries and survey and certification units continue to enforce the Medicare program's integrity standards.
- More information on changes in home health spending can be found on the CMS website, available at http://www.cms.hhs.gov/review/current.asp.

Chart 10-12. Medicare home health care use, 1992–2003

Year	People served	Visits	
	Number (thousands)	Number (millions)	Per person served
1992	2,506	132	53
1993	2,874	164	57
1994	3,179	209	66
1995	3,469	249	72
1996	3,600	265	74
1997	3,558	258	73
1998	3,062	155	51
1999	2,720	113	42
2000	2,461	91	37
2001	2,426	74	30
2002	2,550	78	31
2003	2,685	83	31

Source: CMS, Office of the Actuary, May 2005.

- In the early 1990s, the rapid growth in home health use was a concern to policymakers. Between 1992 and 1996, the number of beneficiaries using home health care increased by more than one million. The total volume of home health was expanding rapidly as the number of visits per user increased along with the number of users.

- In the mid-1990s, the Congress required home health agencies to begin the transition to a prospective payment system, CMS clarified the standards of eligibility for the home health benefit, and the Office of Inspector General increased its scrutiny of home health. Between 1997 and 2000, the number of users fell by one million.

- Many measures of home health use are available at http://www.cms.hhs.gov/providers/hha.

Chart 10-13. The home health product changed after the prospective payment system started

	1997	2002
Average visits per episode	36	19
Average minutes per episode	1,500	940
Percent therapy visits	9%	26%

Note: The prospective payment system (PPS) began in October 2000. Columns do not sum to 100 percent because data were not available for all visit types.

Source: Pre-PPS CMS analysis of the National Claims History file; post-PPS MedPAC analysis of 5 percent Standard Analytic File.

- The types and quantity of home health care services that beneficiaries receive are changing. In 1997, before the PPS, the average number of visits per episode was 36. By 2002, that had fallen to 19 visits. The average length of stay fell from 106 days in 1997 to 56 days in 2002.
- The mix of visits (therapy, aide, or skilled visits as a percent of total visits provided during an episode) has shifted toward therapy (physical therapy, occupational therapy, and speech pathology) and away from home health aide services.
- Information about the use of home health services after the PPS can be found on the CMS website, available at http://www.medicare.gov.

Chart 10-14. Therapy services provided in home health have increased

	Average minutes per episode		
	2001	2002	Percent change
Total	944	945	0.1
Skilled nursing	354	355	0.3%
Home health aide	279	270	-3.2
Physical therapy	180	187	3.9
Occupational therapy	32	34	6.3
Speech (therapy)	7	7	0.0
Medical social work	10	10	0.0

Note: Excludes outlier episodes. Averages by visit type do not total the average total minutes because few episodes include visits of all types.

Source: MedPAC analysis of 20 percent sample of the Datalink file from CMS.

- The home health payment system rewards the provision of therapy services (physical, occupational, or speech). Meeting the therapy threshold for a payment episode produces substantially higher payments for otherwise similar patients. For example, an episode for a patient with moderate clinical severity and moderate functional limitation would be paid $2,440 (base payment × case weight 1.08) if the episode did not meet the therapy threshold and $4,420 (base payment × case weight 1.95) if the episode did meet the therapy threshold.

- The outcomes of care—as measured by average gains in patients' functional status—also showed slight improvements at the same time. More information is available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3D.pdf

Chart 10-15. Aggregate Medicare margins for all freestanding home health agencies remain in double digits, 2003, and estimated 2005

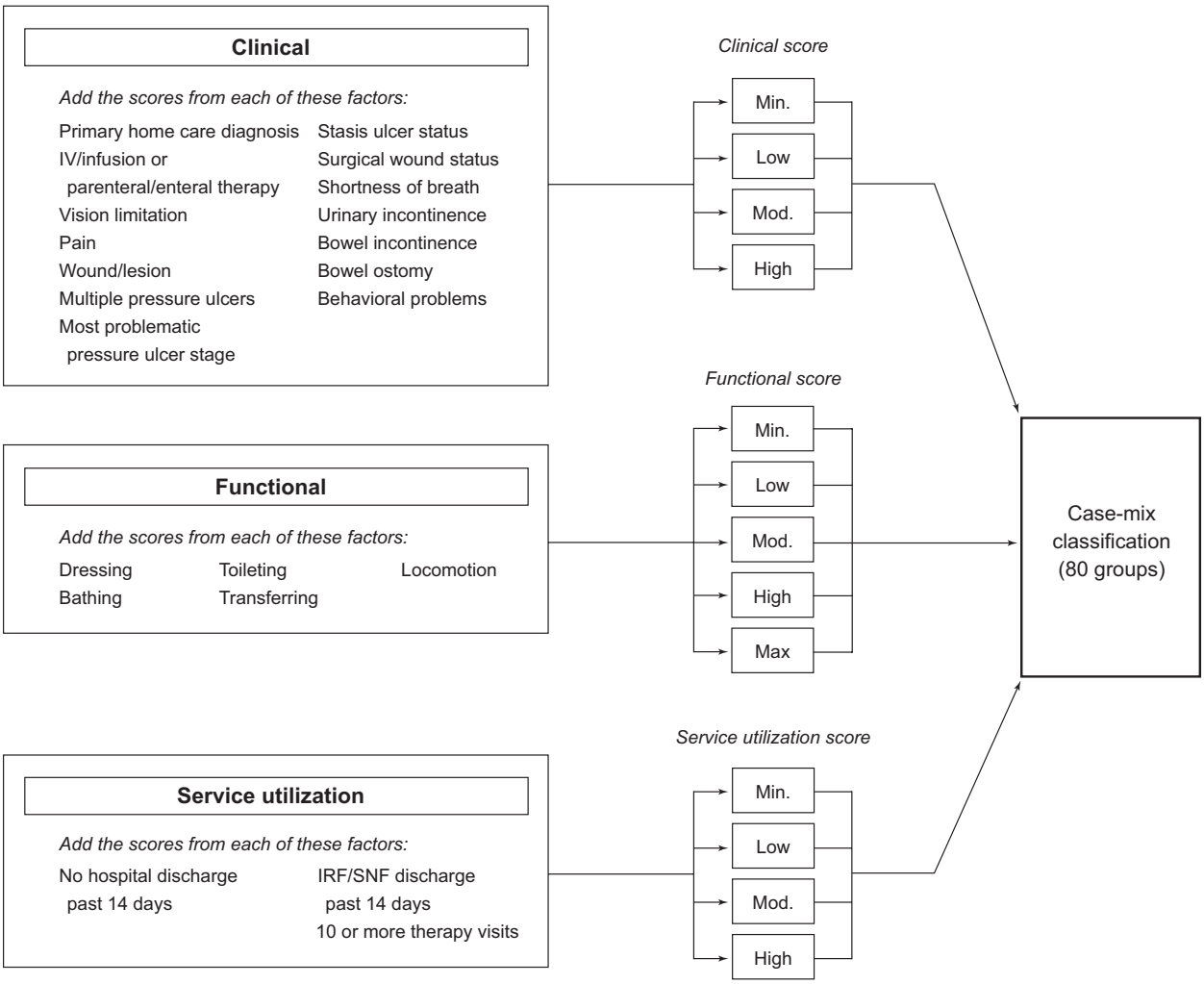
Type of agency	2003	2005
All agencies	13.6%	12.1%
Caseload of agency		
Urban	14.1	13.2
Mixed	13.2	11.6
Rural	10.6	6.1
Type of control		
Voluntary	10.6	9.1
Private	15.8	14.3
Government	5.0	3.3
Volume		
Very small (20th percentile)	10.6	9.1
Small (20th–40th)	10.1	8.6
Medium (40th–60th)	10.9	9.4
Large (60th–80th)	15.5	14.0
Very large (80th)	14.1	12.6

Note: Margins are the difference between Medicare's payments and costs, divided by payments.

Source: MedPAC analysis of Medicare Cost Report file from CMS.

- In 2003, 80 percent of agencies had positive margins. These estimated margins indicate that Medicare's payments are well above the costs of providing services to Medicare beneficiaries, for both rural and urban home health agencies (HHAs).
- These margins are for freestanding HHAs, which composed two-thirds of all HHAs in 2001. Home health agencies are also based in hospitals.
- More information on the adequacy of home health payments can be found in Chapter 3D of MedPAC's March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3D.pdf.

Chart 10-16. Clinical, functional, and service information from OASIS determines patients' home health case-mix classification



Note: OASIS (Outcome and Assessment Information Set), IV (intravenous), IRF (inpatient rehabilitation facility), SNF (skilled nursing facility).

Source: CMS 2000.

- Medicare adjusts payments for episodes of home health based on the expected resource needs of the patients. Patients' clinical status, functional level, previous use of service, and anticipated need for therapy help to predict resource needs.

- The single most common case mix group in 2002 had a low clinical score, a moderate functional score, and minimum service use score. The case-mix classification system includes every combination of scores in the three domains; some of the least likely combinations include a high clinical score but minimum functional impairments.

Chart 10-17. Top 10 resource groups in home health, 2002

Case mix group	Percent of all episodes
HBGJ	9.4
HCGJ	9.1
HBFJ	6.2
HAFJ	5.8
HCGL	5.6
HAGL	5.4
HBGL	5.3
HCFJ	4.8
HDIJ	3.2
HCIJ	3.0
Top 10	58.0

Source: MedPAC analysis of a 20 percent sample of the Datalink file for 2002 from CMS.

- All case mix groups in the home health system begin with the letter "H." The letters A through D indicate patients' clinical condition from minimum complications to high complications. Letters E through I indicate the extent of patients' functional limitations from minimum limitations to maximum limitations. Letters J through M indicate patients' service use from minimum to high.

- Though the case-mix system of the home health payment system includes 80 different groups, these 10 account for almost 60 percent of episodes. Some case-mix groups have very few episodes; for example, the group HDEM had fewer than 200 episodes all year, across the country in 2002.

- The "top 10" lists for other years are very similar to this list.

Web links. Post-acute care

- Chapter 5 of MedPAC's June 2005 Report to the Congress provides information on post-acute care.

  http://www.medpac.gov/publications/congressional_reports/June05_Ch5.pdf

Skilled nursing facilities

- Chapter 2C of MedPAC's March 2005 Report to the Congress, Chapter 3C of the MedPAC March 2004 Report to the Congress, and Chapter 2C of the MedPAC March 2003 Report to the Congress provide information on Medicare margins for skilled nursing facilities.

  http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02C.pdf
  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3C.pdf
  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch2C.pdf

- The official Medicare website provides information on the prospective payment system and other related issues.

  http://www.cms.hhs.gov/providers/snfpps

Home health services

- Chapter 2D of MedPAC's March 2005 Report to the Congress provides information on home health services.

  http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02D.pdf

- The official Medicare website provides information on the quality of home health care, and additional information on new policies, statistics, and research.

  http://www.cms.hhs.gov/providers/hha

Rehabilitation hospitals and units

- CMS provides information on the inpatient rehabilitation facility prospective payment system.

  http://cms.hhs.gov/providers/irfpps

Long-term care hospitals

- Chapter 5 of MedPAC's June 2004 Report to the Congress provides information on long-term care hospitals.

  http://www.medpac.gov/publications/congressional_reports/June04_ch5.pdf

- CMS also provides information on long-term care hospitals, including the long-term care hospital prospective payment system.

  http://cms.hhs.gov/providers/longterm